Recd by Reg 4 on 3/6/03

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

RICA LEWIS-PAYTON
EXECUTIVE DIRECTOR

February 28,2003

Ms. Terrie Morris
Waiver Specialist
Division of Medicaid and Children's Health
Centers for Medicaid & Medicaid
Region IV
Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Dear Ms. Morris:

Enclosed please find responses to the questions regarding our **waiver** application for non-emergency transportation ***services*** per *your* letter of January 14,2003. We hope the information provided will resolve **any** outstanding issues regarding our waiver application.

If you require further assistance or additional information, **please** contact Jan Larsen at 601.987.3902.

Sincerely,

/S/

Rica Lewis-Payton

cc: Sharon **Reed**
Jan Larsen
Brian Smith

Response to Questions from CMS
Regarding the Waiver Application Submitted by
the Mississippi Division of Medicaid for
the Non-emergency Transportation Program

'NOVEMBER 8.2002. COVER LETTER:

QX: Please outline how the delivery date of the requested additional vehicles will potentially impact the cost-effectiveness / savings realized in CY 2003.

Based on discussions with public mass transit providers in Hattiesburg and Jackson before the waiver was submitted, we planned on realizing savings early in the first year of the waiver. However, it appears from *further* discussions with representatives of these organizations. some delay will occur while vehicles are ordered. Our best estimate at this time is that the vehicles will be available in June 2003. Therefore, we are reducing our estimate of savings through the use of public mass transit provider; from $317,616 to $158.808 for the first waiver year. There should be no change in ow estimate for the second waiver year.

Q2: The cover letter states that implementation of the new application process is scheduled for January 2004 and will reduce costs. The letter further indicates that the projected cost savings have been included in projected costs / savings figures. Please explain how a delay of the delivery of additional vehicles and / or delay of implementation of the new application process impact projected savings? Would the waiver still bc cost effective? This information should be included in cost effectiveness spreadsheets (Section V).

The estimated cost savings from the implementation of the application process were figured fox the second (calendar) year of the waiver. Steps to implement the requirement that interested beneficiaries must apply for the NET program would be accomplished during the first year of the waiver so the requirement may be implemented as of January 2004. Please see Q1 above regarding the impact of the delay in vehicle delivery on projected savings.

WAIVER FORMAT SECTION III - PROGRAM IMPACT:

Item A.4 – Application Materials (Pg. 6)

Q3: Please provide a copy of the letter you are currently using to notify beneficiaries of the availability of transportation services.

Individuals who are determined to be eligible for the Medicaid program receive information about all services available to them through the program, including NET assistance through a brochure entitled "What Medicaid Can Do For You" (attached). Persons who are determined eligible for the Medicaid program receive this brochure when they receive their Medicaid identification card. We have also prepared a flyer regarding the availability of NET assistance that is available at the Medicaid regional offices that eligible beneficiaries call with questions about and requests for NE" assistance. Please see Appendix III.A.4.

WAIVER FORMAT SECTION V - COST EFFECTIVENESS (Pgs. 14-16):

Q4: Please resubmit cost effectiveness documentation in a side-by-side spreadsheet format, with and without waiver (historical cost and Year 1 and Year 2 projected costs.) This should includs the number of beneficiaries and total yearly costs on a per-beneficiary as well. as total yearly basis. Also include the financial impact on late receipt of new vehicles, as well as what the impact would be of late implementation of the application process on future cost estimates.

Historical Service Information ICY 2002):

Expenditures: $26,729,232.25
Total Number of Beneficiaries Served: 28,243

Projected Service Information Under the Waiver (CY 2003 and CY 2004)

	Calendar Year 2003	Calendar Year 2004
Benefit cost expected with the waiver	$26,093,214	$26,590,448
Cost expected without the waiver	$26,252,022	$27,302,225
Total number of beneficiaries served	27,448	28,546
Per beneficiary cost expected with the waiver	$950.64	$931.51
Per beneficiary cost expected without the waiver	$95644	$956.44

Impact of Late Implementation of the Application Process on Future Cost Estimates

The application process is expected to provide a monthly savings of $20,931.71. The impact of the delay in the implementation of the application Process on future cost estimates could be determined by multiplying the average monthly savings times the number of months delay. At this time we do not foresee a delay in its implementation.

Q5: What is the annual budget for the enrollment brokers?

The annual budget for the NET coordinator; who are the service brokers is:

Salaries/Fringe:	$1,649,962
Equipment, Supplies, rent	$ 392.000
Total	$2,041,962

Q6: What has been an average / usual per trip payment for:

- Services provided by group providers? $35.64 per one-way trip
- Services provided by individual providers? $17.82 per one-way trip

Q7: How much does this payment vary by service area? (What has been the per trip charge in a high-cost area? In a Iow-cost area?)

The payment for group NET providers ranges from $19 to $50 per one-way trip. The differences in the cost depend on the number of bidders for each region. The more bidders interested in each region, the more competitive the bids for that region were. The average amount paid per trip for individual NET providers among the regions varied from $11.85 to $34.13. These providers are paid on a per mile basis regardless of the area of the state they serve. Therefore, high cost areas are those areas with limited medical providers resulting in the requirement for providers to transport beneficiaries greater distances to access medical services. Cost is also impacted by the availability of individual NET providers, which are usually less expensive than group NET Providers. Some areas of the state have many individual NET providers while others have very few.

QS: Your documentation shows an average monthly cost per beneficiary, statewide, of approximately $250. How many trips does that cover, on average?

The average number of trips per beneficiary, statewide, is 8 round trips. This average is based on all beneficiaries who utilized the program including persons on dialysis. These persons utilize the program approximately 13 times per month.

Appendix II.I.4. (Pg.19)

Q9: Are full dual eligibles (QMB-Plus and SLMB-Plus) eligible for transportation benefits?

These individuals are not eligible for transportation benefits.

Appendix II. K. (Pg. 21)

Q10: Standards reflected here are not consistent with those outlined in the RFB or in your attachment entitled, "Section III- General Terms and Conditions." Please explain the apparent discrepancies among these standards:

On Pg. 21 of the preprint, the standards are:

- pickup not more than 45 minutes prior to appointment, plus travel time
- wait time no more than 30 minutes after appointment
- return trip not more than 45 minutes to return destination, plus travel time
- no more than 30 minutes wait when being transported between two medical providers

Pg. 8 of the RFP reflects that the beneficiary shall not be in transport more than 30 minutes plus the time necessary to drive to the provider and no more than 30 minutes to return destination plus the time necessary to drive to the destination. Section 111, General Terms and Conditions#12, states that a NET provider agrees not to keep a beneficiary en route from the pickup point to the destination more than ninety (90) minutes one way, excluding travel time.

The standards indicated on the pre-print are the current standards. The standards as listed in the RFB, page 8 were current when the RFB was issued in February 2001. The standards included in Section III, General Terms and Conditions #12, which conies from the NET individual provider participation agreement, are the standards for the individual providers when this agreement was developed. A new individual provider agreement has been drafted that includes the same standards as those for the group providers. We plan to re-enroll all NET individual providers beginning March 2003 utilizing the new individual provider am——ent.

Appendix III.A. 1. Notification Process (Pg. 22)

Q11: How will you ensure transportation services guaranteed by the program for beneficiaries who do not complete (or have not yet completed) the application?

Beneficiaries who utilize the NET program will be advised by mail that they will be required to complete an application for NET assistance. Beneficiaries will be given a specified amount of time (we estimate two months) to complete the application and return it to the Division. They will continue to receive NET assistance. If they do not submit an application by the specified deadline, they will be sent one reminder that they are required to submit the completed auplication and be given a second deadline by which to submit the application (we estimate one month). If they have not submitted the application by the second deadline, NET services will no longer be available to them until such time as the application is submitted, documenting their need for assistance. The NET coordinators will be available to answer questions the beneficiaries may have about the application.and to remind them to complete and return tho application when the beneficiaries contact the Coordinators for NET services. Please see Appendix III.A.1 of the waiver application.

Q12: The NET fact sheets state, "You must call at least 72 hours or three (3) working days before your scheduled appointment." Outline the procedures for handling requests for transportation to urgent care services, in light of the fact that those services must be provided within 48 hours.

Beneficiaries are asked to provide a 72-hour notice of their need for NET assistance. When beneficiaries wait until the last moment to request NET assistance, it is very difficult for Providers to handle the scheduling difficulties this causes. However, NET coordinators are advised in training that if a beneficiary calls with less than a 72-hour notice that she requires NET assistance. they are to assist the beneficiary if at all possible. This is especially important in cases where a beneficiary is referred by her medical. provider for additional medical assistance, and the appointment for the additional assistance is scheduled within 72 hours of the beneficiary's current appointment.

Q13: Please outline your procedures for handling transportation requests for which beneficiaries are unable to provide the requested three days notice (for example, a follow-up office visit requested by the physician in **two** days).

See Question 0 12 above. Also. i fa beneficiaryrequires transportation for medical assistance **as** a result of assistance alreadv received that dav. the providers are required to transport that beneficiarv. For example. if a beneficiary i s transported for dialvsis treatment and then clots. the provider must **transport** the beneficiary for declotting assistance **and** then transport the beneficiary **back** to **the** dialysis center.

Q14: To date, how **have** beneficiaries been notified about the program?

Persons who become eligible for the Mississippi Medicaid program receive information about the program including a flyer which describes the **services** available to them. NET services are described in this flyer. The Division of Medicaid has also prepared flyers specifically about the NET program. These flyers will be available to interested beneficiaries through the Medicaid Regional Offices. Please see Appendix **III.A.4.**

Q15: **Are there** provisions for beneficiaries with language / literacy issues to obtain assistance in completing the application form?

The Division of Medicaid has established the Language Line. Through this **service,** interpreters axe **made** available to **any** person who does not speak English **and** who requests information about the Medicaid program including NET services. This information includes the provision of assistance in completing applications for Medicaid. This same type o fassistance is available to non-English speaking persons who **seek** assistance in completing the application for NET services. (See Appendix III.A.4.)

Q16: Please consider outreach efforts such as telephone assistance **provided** by a customer service representative who completes the form with the beneficiary via telephone, then mails the form to the beneficiary for signature and date, and include a self addressed stamped envelope for return mailing.

Currently, the assistance suggested above is available to persons who apply for Medicaid benefits. This same service will be extended to persons who are applying for NET assistance.

Application for Non-Emergency Transportation (NET) **Services** (Pg. 24)

Q17: In future printings, please consider changing item **4** to read, "Please explain how yov are transported to go shopping, place of **worship** and other **places."**

Thank you for this suggestion. We will make the change.

Q18: Where are the applications to be sent? Is the local NET coordinator responsible for approving them or, are the applications to be sent to the State central office for processing?

Our plan is to hire temporary workers to be supervised by Bureau of Compliance and Financial Review (BCFR) staff or by ACS to process the large number of applications we expect to receive when the application requirement is implemented. After this initial enrollment period. the coordinators will process and approve applications for NET assistance.

Q19: How will beneficiaries be notified that they have been approved or disapproved for transportation services?

The beneficiaries will be notified in writing of the status of their applications as part of the enrollment process. We will make provisions through the NET software ox through word processing software to allow the production of notification letters, to be sent through the mail, advising beneficiaries of the status of their applications.

Initial and Reminder "Dear Medicaid Beneficiary" letters (Pgs. 25-26)

Q20: In the last paragraph, for the phrase, "please contact your local. NET coordinator," please consider adding: "(See enclosed fact sheet for the phone number of the Medicaid Regional. Office in your area.)" If the fact sheet will not be included with both letters, please clarify how beneficiaries will be notified of the toll-free phone number to contact the local NET coordinator, as well. as a TDD line for hearing impaired.

Thank you for the suggestion. We will include in the reminder letter a listing of the toll-fiee numbers fox each Regional Office as well as information to help the beneficiary know which office to call.

Q21: After the completed application materials are received from the beneficiary, does the State send an acknowledgment of receipt?

The beneficiary will be notified in writing by the Division of Medicaid about the final decision regarding her eligibility for NET assistance. Interim notices are not planned at this time.

Q22: Please identify any other barriers that you anticipate may be created by the new application process and provide an explanation of how you will overcome those barriers.

Some of the beneficiaries who are currently using the program may resist completing the application for NET services since they have not been required before to do so. The NET staff will work with the beneficiaries to explain the purpose of the application and to provide any assistance they may require in completing it.

Q23: In the section, "For More Information Call," please consider substituting the (601) number with a toll-free 800 or 888 number and provide a **TDD** number for the hearing impaired.

Thank you for the suggestions. The general information brochure for the Medicaid program which individuals receive when they become eligible for Medicaid services includes a toll free number for the state office they can call. Also, each of the numbers listed for the regional offices in the NET brochures is a toll-free number. By calling their local regional offices at the toll-free numbers, the beneficiaries are able to speak with staff who will actually arrange NET assistance for them. Persons who are hearing impaired may reach the Division of Medicaid by calling the Mississippi Communications Relay Service which accepts text calls from persons who use TTY devices and then interprets these calls to the party with which the hearing impaired Person wishes to communicate. This is a toll free service.

Q24: Please consider including this information in future printings of all brochures, fact sheets, and beneficiary letters.

Thank you for the suggestion. We will include it in future printings.

Section III- General Terms and Conditions (Pg. 2 of 2)

Q25: Please explain the statement found under item 11 that, "DOM has no liability for negligent acts or omission of the NET provider."

This statement is included in the document under the advice of our legal staff. This agreement is used for enrolling the individual NET providers who are not employees of the Division. This statement advises them that they are responsible for the service they provide and any consequences of it. The Division investigates all complaints against any provider whether that provider is an individual provider or a group provider. It is up to the provider to address and correct the cause of any substantiated complaint.

Q26: How were / will providers be informed of these timeframes to assure provider compliance?

Because the Mississippi Medicaid NET program uses an in-house broker model which has been in place for some time, the current providers are aware that transports must be prior approved by the NET coordinators and that the coordinators choose the provider for each approved transport. The timely compliance of the current providers will be assured.

The public transit providers, which will become enrolled as Medicaid providers, are aware that we are most interested in enrolling them as providers as soon as possible. They have administrative issues, such as board approvals, routing, acquisition of equipment, etc. which they are currently addressing so that they may begin to provide the services as discussed as soon as Possible.

Q27: Please revise future contracts to reflect timeframes most beneficial to beneficiaries.

We will ensure that providers have ample time to meet timeframes, thereby ensuring the provision of NET assistance to beneficiaries with as little disruption as possible.

Q28: Please define and provide examples of what is considered "irregularity" referenced in item 15.

The term "irregularity" refers to conditions which cause our staff to question the claims submitted for payment. For example. if an individual provider submits a claim for mileage which seems too high given the route taken by the provider or if the provider traveled a route that was unnecessarily long, the coordinator will hold that claim until the provider justifies the mileage claimed. As another example. the coordinator will hold a claim submitted by a provider if the provider does not submit the rewired documentation from tho medical Provider that the beneficiary was transported to that medical provider's office.

Request for **Bids**

Q29: This document serves to bind group providers and outlines the State's expectations regarding their performance. What mechanisms are in place to monitor individual providers and volunteer providers not under contract with the State (and their vehicles)?

Individual and volunteer drivers are the same. These providers are monitored as **follows:**

1. The NET coordinators review and submit for payment all individual provider claims. The NET coordinators review mileage and ensure that the medical providers to whom the beneficiaries were transported have indicsted that the beneficiaries were delivered to their location.

2. The NET coordinators are responsible for processing individual provider applications. The NET coordinator will visually inspect the applicant's vehicle and ensure that the vehicle has a current license tag and inspection sticker, that the vehicle has proper insurance coverage. and that the provider's driver license is valid. Once a wear, the provider must bring the vehicle back to the ooordinator when the inspection sticker and license tag for the car is renewed (usually in the same month), and when the provider brings in proof of insurance coverage.

3. Individual providers are monitored through the complaint process. All complaints are investigated and providers are subject to sanction or removal from the program. Investigations may include examination of claims and inspection of vehicles.

4. Individual providers may also be monitored by the Bureau of Program Integrity through random reviews or specific requests from the BCFR or other sources.

Bid Evaluation - Pgs. 16-18

Q30: In regard to the evaluation of bids from group providers, your documentation reflects that cost represents a relatively small factor (300 of a total 1000 points.) Please **provide** additional information on what the State emphasizes in evaluating the business component of bids (700 of 1000 points).

Twenty-one requirements with which each bidder was required to comply were established and served as the **business** component of the RFB. These requirements are also included in the provider contracts and address areas of service and accountability on **which** the Division of Medicaid has placed emphasis to ensure the provision of quality services to Medicaid beneficiaries. During the evaluation process, the evaluation team reviewed each bidder's response to the requirements in order to determine **if** the bidder's response was sufficient **and** detailed, thereby demonstrating that **the** bidder had considered all requirements **and** developed a specific approach to meeting each requirement. The evaluation committee reviewed each bid and as a group make a decision regarding the score that the bidder received. The evaluation team assigned 0 to 4 points for each response as follows:

0 - No response
1 - Responded but did not address the requirement.
2 - Responded but **the** answer does not allow the provider to sufficiently meet the requirement
3 - Responded and allows the Provider to meet the requirement.
4 - Responded and the response exceeds the minimal requirements and improves the providers ability to provide quality services.

The highest raw score for each region was awarded 700 points. The remaining bidders were awarded points using the following formula:

$$\frac{X * 700}{N} = Z$$

Where X = bidder's raw score
N = the highest raw score for the **bid** region
Z = assigned points

Appendix III. C.3.c.: Selection **criteria** (Pg.33)

Q31: Please provide the screening process and quality and performance standards for individual / volunteer providers, or any other providers outside of the RFB/ contract **process.**

Individual **drivers are the** only other **providers** that provide transportation outside the RFB/contract process. These providers **must** meet the requirements set forth in the NET provider participation agreement for individual providers. This document **was included** in the waiver under Appendix C.1.

Appendix IV.A. Access to Care and Quality of Services: General

Q32: Providers have complained of poor customer service and poor resolution of problems on the part of the fiscal agent. How have these complaints been addressed?

The Division of Medicaid is working closely with ACS to address customer service and problem resolution issues. These issues are not specific to the NET providers. ACS staff have begun attending the weekly DOM management staffings so that they are kept current on such issues. The DOM Bureau of Systems Management meets with the ACS executive staff on a weekly basis to discuss system issues and changes. DOM executive management meets with ACS executive management on a monthly basis to address concerns, including provider complaints. The BSM staff provides to the DOM executive management a report card each month which identifies specific areas requiring attention from ACS.

433: Several complaints were received that the NET Coordinators are too bureaucratic in their relationships with both providers and beneficiaries, in that they meet the letter of the program policy, but not the spirit. How has this problem been addressed?

We understand that this has been a concern with a small number of the coordinators. In the training that is conducted with coordinators, they are advised that the purpose of the program is to ensure access by eligible beneficiaries to Medicaid services. Therefore, they should be of as much assistance as possible to eligible persons requesting assistance. For example, we ask beneficiaries to provide a 72-hour notice of their need for NET services. But we are also aware that situations do occur whereby they are unable to provide such notice. In those cases, the coordinators are expected to assist the beneficiaries. However, they are expected to uphold program policies and procedures to ensure equal and consistent availability of services throughout the state. The state staff are available to assist with any special circumstances which may arise.

Q34: Centralization of NET Coordinators may result in more consistent policy application and in reduced administrative cost. Has any further consideration been given to this possibility?

We understand the benefits of such a model. Such a major change as eliminating the coordinators' presence in their local communities will have a significant effect on the beneficiaries, medical providers, NET providers and others. We have considered it but have decided not to pursue it at this time.

Appendix IV.B.: Complaint Process

435: How will you ensure the continuation of transportation benefits to a beneficiary who has registered a complaint?

We currently provide such assurance. Beneficiaries who register complaints continue to receive NET assistance either from their current provider or from an alternate provider, depending on the circumstances of the complaint.

Q36: What mechanism is utilized to inform beneficiaries that if hearing findings are not in their favor, they may be responsible for the cost of the denied service?

When service benefits for a beneficiary change as a result of income recalculations, availability of third party health insurance, etc. the beneficiary is advised of the change and its effect on the beneficiary's receipt of services. Per the brochure described in 039 below. beneficiaries are notified that the Division. conducts fair hearings regarding services and are provided a number to call for information regarding the hearing process. including possible outcomes of it.

Q37: Please outline the process by which you (a) identify poorly performing providers and (b) implement and monitor quality improvement activities for such providers.

Poorly performing providers are identified primarily through our complaint Process (see Appendix IV.B.), our monitoring activities (see Appendix IV.E.2.), and our beneficiary satisfaction survevs (see Appendix N.E.1.).

NET Policy and Procedure- Administrative Hearings

Q38: How will you ensure the continuation of transportation benefits to a beneficiary during the State fair hearing process?

The Division of Medicaid arranges all NET services and thereby ensures services to beneficiaries throughout the hearing process until a final decision is made that the beneficiary is not eliaible to receive services.

439: When and how are beneficiaries notified of their right to a State fair hearing?

Persons who are determined eligible for the Medicaid program receive with their Medicaid identification cards a copy of the brochure entitled 'What Mississippi Medicaid Can Do For You." A revised copy of this brochure is attached. On the second page, in the Section Important Notices – Fair Hearings, the beneficiary is advised regarding fair hearings which concern eligibility and services. The Division of Medicaid is also planning a mass mailing of this brochure in April 2003 to all heads of households which include members enrolled in the Medicaid program.

Q40: Are beneficiaries informed that if hearing findings are not in their favor, they may be responsible for the cost of the denied service?

Please see Q36 above.

Q41: On page 2 of the policy, paragraph 1 refers to appeals filed by members of a couple. Medicaid beneficiaries are found eligible individually and are treated individually with respect to receipt of benefits, etc. Please consider revising this policy to reflect Medicaid eligibility conventions.

Under Mississippi state law, the Division of Medicaid is required to conductioint (at the same time) hearings if requested to do so by a couple. However, each member of the couple is considered individually with regard to the eligibility, receipt of benefits, etc.

Appendix IV.C.2, Paragraph 3 (Pg. 36)

Q42: What percentage of the beneficiaries utilizing NET services is surveyed? Please provide aggregate findings from your most recent survey.

For purposes of the survey, a random sample of fifty beneficiaries from each of the thirty-two service regions are chosen for a total of 1,600 beneficiaries who have used NET services over a certain time period (usually a three month period). During Fiscal Year 2002, the average monthly number of beneficiaries utilizing the NET program was 8,094 beneficiaries. The associated percentage would be approximately 20% (1,600/8,094).

During Fiscal Year 2002, BCFR conducted two surveys of beneficiaries using NET system for transports to their medical appointments. For each survey, the BCFR randomly chose fifty unduplicated beneficiaries from each of the thirty-two NET regions who used NET services. The first survey was sent to beneficiaries who used NET at least twice in the months of May and June 2001. The surveys were mailed in October of 2001. The second survey was sent to beneficiaries who used NET at least twice in the months of February and March 2002. These surveys were mailed to beneficiaries during the month of May 2002.

For the first survey, a total of 1,564 surveys (Note: three regions had fewer than fifty unduplicated beneficiaries) were mailed to beneficiaries. The total number of beneficiaries who responded was 731, providing a response rate of forty-seven percent. For the second survey, a total of 1,600 surveys were mailed to beneficiaries. The total number of beneficiaries who responded was 791 providing a response rate of forty-nine percent. Each survey contained a total of eighteen questions plus three additional questions for beneficiaries requiring wheelchair transportation. The survey questions were broken down into the following areas:

1. Overall satisfaction - beneficiaries were requested to rate the service provided by the company that transports them as either Excellent, Good, Fair, or Poor.

2. The arrangement process – questions were designed to determine whether the beneficiary experienced any problems in contacting their NET coordinator to request transportation services.

3. Transportation experience – questions were designed to determine the beneficiaries' satisfaction with their drivers and the vehicles in which they were transported.

4. NET provider's compliance – questions were designed to determine whether the NET provider was in compliance with certain safety and contractual requirements.

5. Access to public transportation – beneficiaries were asked if other transportation was available in their hometown that could transport them to medical appointments.

6. NET provider's compliance in transporting beneficiaries who use wheelchairs – beneficiaries were asked specific questions to ensure providers were safely transporting beneficiaries who use wheelchairs.

The survey results indicate that in most instances, beneficiaries were happy with their transportation services and providers were generally in compliance with contractual requirements. As a result of the survey, the BCFR has identified several specific areas that will need to be addressed with the providers. These areas are:

1. providers should ensure that drivers ox passengers do not smoke while transporting beneficiaries:,
2. providers should ensure vehicles are properly marked with the provider's business name;
3. providers should ensure that employees wear photo id badges;
4. providers should ensure that their drivers provide business cards with the providers toll-free number: and,
5. providers should ensure drivers are trained on the proper procedures for transporting wheelchair bound beneficiaries.

In addition, the BCFR identified several actions which would improve the beneficiary's access to the NET cookdinator. The BCFR will work with the Bureau of Eligibility to address both staffing concerns and staff training issues to improve the beneficiaries' ability to communicate effectively with the NET coordinators.

Q43: Is there a process for the initiation and monitoring of corrective action plans (CAPs) for problems identified by the surveys?

Providers will be advised of the results of the survey including those areas where their performance is good and those where problems were noted. Providers will be required to address any problem areas through a CAP. Staff will monitor the success of providers in implementing the policies and procedures outlined by the providers in their CAPs to ensure that problems noted through the surveys ate corrected.

444: *Are* providers subject to sanctions if they do not formulate *CAPs* or do not implement changes outlined in CAPs?

Providers are required by the terms of their contracts to be responsive to inquiries from DOM and to respond accordingly. Providers are aware per these contracts that DOM may sanction them for failure to meet any terms of the contract. If providers do not formulate and implement CAPs to the satisfaction of DOM, they may be sanctioned.

Appendix V, C (Pg. 51)

Q45: Please describe why the State chose a 4% growth rate for beneficiaries.

This growth rate was determined through an analysis of the growth rate in the number of beneficiaries who utilize the program as well as overall growth in the Medicaid program over a recent 12-month period. We also considered the growth in the program over several years and determined that the growth in the program was

slowing somewhat. Therefore, in estimating the savings we would realize two years in the future, we used a somewhat conservative estimate of the projected growth for that period.

Q46: Why are there no inflationary increases reflected in the average cost per beneficiary calculation? Does the State believe that the cost per transport will remain constant and if so, why?

DOM did not request additional funds for the coming fiscal year for the Medicaid program; therefore, we did not project increases in the cost of the NET program.

FILE: MS NET / RAI

Office of The Governor
Division of Medicaid

What Mississippi Medicaid Can Do For You

MEDICAID

Services

☑ **Office Visits and Family Planning Services** - Medicaid pays for 12 office visits from July 1st to June 30th each year for adults and 24 office visits from July 1st to June 30th each year for children. (Children can get more visits if the doctor sends Medicaid a plan of care that says there is a medical need for the child to have more visits).

☑ **Hospital Care - Inpatient Services** - Adults get 30 days of inpatient hospital services from July 1st to June 30th each year. Children can get more visits with a plan of care.

☑ **Hospital Care - Outpatient Services** - Adults get 6 outpatient hospital visits from July 1st to June 30th each year. Children get 12 outpatient hospital visits from July 1st to June 30th each year. Children can get more visits with a plan of care. Emergency room visits count as outpatient visits.

☑ **Prescription Drugs** - You may get five (5) prescriptions per month, If your doctor gets prior approval you can get two (2) more prescriptions for a total of seven (7) prescriptions per month. Children under 21 years of age may get more than five (5) prescriptions if the doctor sends Medicaid a plan of care.
If there is a drug that costs less and works as well as the name brand, your doctor must prescribe the drug that costs less.

☐ **Eyeglasses** - Adults can get one (1) pair of eyeglasses every five (5) years. Children may get one pair of eyeglasses per year. If a child needs more than one (1) pair of eyeglasses in a year, the doctor has to send Medicaid a plan of cam which says there is a medical need for the child to have another pair of eyeglasses,

☑ **Home Wealth Services** - Adults gel 60 home health visits from July 1st to June 30th each year. Children can get more visits with a plan of care.

☑ **Long Term Care Services** - Medlcald pays for nursing facility care, intermediate care facility services for the mentally retarded, and psychiatric residential treatment facility care (under age 21).

☑ **Inpatient Psychiatric Care** - This service Is only available for persons under age 21 In a free-standing psychiatric hospital.

☑ **Non-Emergency Transportation Services** - Medicaid will help eligible persons to travel to and from medical appointments when they have no other way to get there. *Call 1-800-421-2408* to find out how to get help with transportation to your appointment.

COVERED SERVICES ALSO INCLUDES

☑ **Chiropractic Services**

☑ **Dialysis Services**

☑ **Dental Extractions and Related Treatment**

☑ **Durable Medical Equipment and Medical Supplies**

☑ **Hospice Services**

☑ **Physician Services, Physician Assistant Services, Nurse Practitioner Services**

OVER

Programs

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The **EPSDT** Program provides preventive services for children under **21** years of **age. Your** child can **be** seen **at** the county **health** department **or** at one **of** the EPSDT doctors or clinics in **your** area **that takes** Medicaid. **With** this program you can **get** free check-ups **for** your children. Any doctor, clinic or county health department will give your child **a** complete check-up. Contact your Human Services worker, doctor **or** clinic that **take** Medicaid. To **learn** more about this program, call the **EPSDT** program at ***1-800-421-2408.***

Home and Community-Based Services (HCBS)

HCBS programs offer in-home services **to** help people live at home instead **of** nursing homes. These services are for certain **elderly,** disabled, and/or mentally retarded/developmentally disabled Medicaid beneficiaries. You must apply and be approved for these services. **To** learn more about **this** program, call the Home and Community Based Services program at ***1-800-421-2408.***

Important Notices

Other Health Insurance (Third Party Liability / TPL)

You must report to the Division **of** Medicaid any health insurance you may heve. If you have health insurance and Medicaid, you must give your insurance information to your doctor when you **got** services. Medical payments from any **source** (insurance, liability coverage, Workers' Comp, employer liability, CHAMPUS, lawsuits, accidents, or other) that you get for services covered by Medicaid must be reported **to** Medlcald. In order **to** be eligible for Medicaid, you must assign your rights to medical payments from any source to the Divlsion of Medicald.

Fair Hearings

The Mississippi Department of Human Services (DHS) holds fair hearings for Medicaid eligibility decisions that are handled by **DHS** which Includes Medlcald for families, chlldren and pregnant women. You may call **DHS** at ***1-800-345-6347***.

The Social Security Administration (SSA) holds fair hearlngs for Medicald eligibility declslons that **are part of an** SSI (Supplemental Security Income) decision for low income **aged,** blind and disabled Individuals. You **may** call **SSA at** ***1-800-772-1213.***

The Division of Medicald (DOM) **holds** fair hearings far Medlcald eligibility decisions for aged and disabled individuals handled by a Medicaid Reglonal Office. **DOM also** holds fair hearings on matters about services covered **by** the Medicald program.
You may call DOM at ***1-800-421-2408*** for the office nearest you.

What To Do If. . .

- your health care provlder **is** giving a service that you **think** you **may** not need ***or***
- you think your health care provider may be hilling for services you did not **get** ***or***
- your provider wants you to **pay** far a service you thlnk Medicald covers.

If **you** have **any** of these situations, call **the Bureau** of Program Integrity Hotline at ***1-800-880-5920.***

Copayment

- **A copayment Is when you have to pay a small cost for the service you get.**
- **Children under the age of 18, pregnant women, and persons in** nursing tomes **do** not have **to pay a copayment-**
- **You do not have to pay a copayment if you** are **getting family planning** services **or emergency services** in **a emergency room.**

The following fees are paid to the providsr **at the time service is** provided.

Ambulance	**per trip**	**$3.00**
Dental	**per visit**	**$3.00**
Federally Qualified Health Center	**per** visit	**$3.00**
Home Health	**per visit**	***$3.00***
Hospital Inpatient	**per day**	**$10.00**
Hospital Outpatient	**per visit**	**$3.00**
Physician	**per visit**	**$3.00**
Prescription	**Per prescription for generic drug6**	**$1.00**
	Per prescription for name brand drugs	**$3.00**
Rural Health Clinic	**per** visit	**$3.00**
Eyeglasses	**per pair**	**$3.00**
Durable Medical Equipment, Orthotics, and Prosthetics	**up to**	**$3.00**